Illinois D	epartment of Public	Health				
STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6001267	B, WING		C 05/30/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	TATE, ZIP CODE		
	VOOD CARE CENTRE	2313 NOR	TH ROCKTO	N AVENUE		
(X4) ID PREFIX TAG					D BE COMPLETE	
S 000	Initial Comments		S 000			
	Complaint Investiga	ation #1913819/IL112534				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations.				
	300.610 a) 300.1210 b) 300.1210 d) 5) 300.3240 a)					
	Section 300.610 R	esident Care Policies				
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory confinersing and other policies shall compositive the facility and shall composit the facility and shall compositive the facility and shall compo	divisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating I be reviewed at least annually documented by written, signed				
	Section 300.1210 Nursing and Person	General Requirements for nal Care				
	care and services to practicable physical well-being of the re- each resident's com- plan. Adequate and	shall provide the necessary o attain or maintain the highest l, mental, and psychological sident, in accordance with nprehensive resident care d properly supervised nursing care shall be provided to each		Attachmen Statement of Licensu		
		e total nursing and personal				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE 06/14/19

STATE FORM

FURIVI APPRUVEU Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6001267 05/30/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2313 NORTH ROCKTON AVENUE AMBERWOOD CARE CENTRE ROCKFORD, IL 61103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG DEFICIENCY**) S9999 Continued From page 1 S9999 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection. and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect An owner, licensee, administrator, a) employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met as evidenced by: Based on interview and record review the facility failed to monitor a resident's skin under a medical

Illinois Department of Public Health

intervention.

device, asses a wound, identify a wound as a pressure injury, and put interventions in place to

unstageable pressure injuries to R1's right foot from a medical device which required surgical

This applies to 1 of 3 residents (R1) reviewed for

This failure resulted in R1 developing

prevent a pressure injury.

pressure in the sample of 3.

STATE FORM

Illinois D	epartment of Public	Health				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		 L6001267	B. WING		05/3	0/2019
			DEES CITY S	TATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		TH ROCKTO			
AMBERV	VOOD CARE CENTRE		RD, IL 61103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
S9999	Continued From pa	age 2	S9999			
	Nursing) at the ass currently residing, son April 17, 2019, which be a continuous and tender blister, it was unstable admitted to the wound, a wound waintravenous antibious on May 29, 2019, Nurse for R1's Ortlan open reduction March 6, 2019, to had one surgical in R1's right ankle. Winitially after surger follow up appointments and at that follow were removed and incision. V5 said to incision at that time applied. V5 stated after the surgical to phone call from V6 Practical Nurse -Laken the surgical dressing changes asked V5 what she V3 to take off the land change the dressing the dressing thange the dressing than the dr	at 10:50 AM, V6 (Director of isted living center where R1 is said R1 was transferred here with what was reported as a t foot. V6 stated "R1 had a R1's right foot, it was down to on. R1's wound was beyond a ageable. R1 has since had to hospital for surgery of that ac placed, and has had				
	removed at least of	daily to inspect the skin and				7
		nere was no mention of any int." V5 stated "the expectation				0

Illinois Department of Public Health

6899

FURIVI AFFRUVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 05/30/2019 IL6001267 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2313 NORTH ROCKTON AVENUE AMBERWOOD CARE CENTRE ROCKFORD, IL 61103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Continued From page 3 S9999 is the facility would remove the surgical boot daily to inspect the skin and complications of not removing the boot could be pressure injuries." V5 said R1 had a follow up appointment on April 2, 2019, and R1 had a wound on R1's right outer foot. V5 stated "the wound was not part of the surgical incision, it was a red, open blister like wound caused from the boot rubbing on R1's foot. The doctor gave orders to take the boot off at night and leave open to air, and put the boot on during the day. R1's wound is a pressure injury from the boot and by the time R1 left the facility, R1's tendon was exposed. R1 has had to have a wound vac applied to the wound and has had surgery done on the wound as well." On May 29, 2019, at 9:56 AM, V4 (Registered Nurse) said R1 had a right ankle fracture and was at the facility for physical therapy. V4 stated "R1 had a wound R1 got from the boot on R1's ankle." On May 29, 2019, at 10:01 AM and 1:45 PM, V3 said R1 initially had a soft splint on her right lower leg (which was not to be removed) and then went to a follow up appointment on March 19, 2019 and came back with a boot on. V3 stated she did not remove the boot on March 19, 2019 to do an assessment of R1's surgical wound, the first time she removed the boot and did a skin assessment was on March 26, 2019. V3 said when she did R1's wound assessment on March 26, 2019, R1 had a surgical incision on her right outer ankle and a wound on her right outer foot. V3 stated "R1's wound looked like a blister from the boot."

On May 29, 2019 at 1:45 PM, V3 stated "yes R1's wounds could have developed during the period March 19, 2019 through March 26, 2019 (the 7

days without a wound assessment).

	epartment of Public IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	ESURVEY
AND PLAN OF CORRECTION				A. BUILDING:		PLETED
		IL6001267	B. WING		C 05/30/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
AMBERV	VOOD CARE CENTRE		RTH ROCKTO	N AVENUE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE
S9999	Continued From pa	ge 4	S9999			
	documents R1 was March 8, 2019, with right ankle fracture, documents R1 is al (aware of person, p (the Facility) for the and plans to go bac R1's facility face sh on 4/17/19. R1's Wound Assess March 12, 2019, for wound, shows a pic extremity in a soft of surgical incision, pr skin=100% and no	e dated March 8, 2019, admitted to the facility on a diagnoses of hypertension, goiter. This same note ert and oriented times three clace, and time) and is there rapy and pain interventions to the home with R1's husband. He shows R1 was discharged sment Details Report on R1's right lower leg front the current on admission, intact measurements.				
	wound, shows a pic extremity in a surgic	cture of R1's right lower cal boot with wound cal incision, present on				
	March 26, 2019, for wound, shows a pic extremity with steri R1's right outer ank distal to the surgical foot containing 25%	sment Details Report on R1's right lower leg front cture of R1's right lower strips covering an incision on the and a second wound area il incision on R1's right outer white fibrinous slough. This fy the type of the distal wound.				
	16, 2019, (the day large) right lower leg front	sment Details Report on April pefore R1 discharged) for R1's , shows the distal wound has solough and 35% necrotic				

tissue.

Illinois Department of Public Health

STATE FORM

	epartment of Public		(VOLANI) TIDI E	CONCTRUCTION	L/V2\ DATE	CHRVEY
	"ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. DOILDING.			
		IL6001267	B. WING			C 3 0/2019
					1 031.	3012013
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
AMBERV	VOOD CARE CENTRE		TH ROCKTO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
\$9999	Continued From pa	nge 5	S9999			
	right inner ankle da wound measuring (centimeters). R1's Report dated April now has 70% sloug Wound Assessmer wound has now de necrotic tissue. The a "surgical incision only surgical incision ankle). R1's Progress Note Notes from March 2019 (7 days) does	sment Detail Report for R1's ated March 26, 2019, shows a 5.0 by 1.0 by 0.1 cm as Wound Assessment Detail 1, 2019, shows the wound bed gh. On April 9, 2019, the at Detail Report shows the teriorated to slough and the reports identify the wound as " (per the orthopedic nurse the on was on R1's right outer the sand Daily Skilled Progress 19, 2019 through March 26, is not show R1's surgical boot				
	assessed. R1's Telephone En 2019 (a telephone shows "V3 stated to changed since the patient was seen by	R1's skin under the boot was accounter Note dated March 26, conversation with V5 and V3) he dressing has not been 19th of March when the by the orthopedic doctor, asked ssed the incision and V3 stated covered."			38	
	transferred to on A	in Review from the facility R1 pril 17, 2019 shows "R1 was nstageable wound to anterior				
	Guidelines show "(a resident should of assessment on all are dressings, rem	and Wound Care Protocol the licensed nurse who admits complete a comprehensive skin resident admissionsif there nove all dressings and measure				
		nent all injuries. Include dth, length, depth, exudate."				

Illinois Department of Public Health STATE FORM

Illinois D	epartment of Public	Health			FURIN	APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED	
						С	
		IL6001267	B. WING			30/2019	
			ADDRESS, CITY, STATE, ZIP CODE				
NAME OF F	PROVIDER OR SUPPLIER						
AMBERV	VOOD CARE CENTRE		RTH ROCKTO DRD, IL 61103	N AVENUE			
(X4) ID		TEMENT OF DEFICIENCIES	ID	CTION	(X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETE DATE	
S9999	Continued From pa	ge 6	S9999				
	Policy dated July 20 related pressure injudevices designed a	ure Ulcers/Injuries Overview 017 shows "Medical device furies result from the use of and applied for diagnostic or esthe injury should be aging system."					

Illinois Department of Public Health STATE FORM